

4767

CERTIFICATE OF DEATH

Reg. Dist. No.

04749

261-

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Ann</u> Last <u>Byrd</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Parksley, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Edward Drummond</u>		14. MOTHER'S MAIDEN NAME <u>Mary Emily Abbot</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or on) <u>No.</u>		16. SOCIAL SECURITY NO. <u>219-07-1302</u>	
17. INFORMANT <u>Sarah Jane Byrd - Marion Sta., MD</u>		Address <u>206</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Carcinoma of lungs -</u> DUE TO (c) <u>Venous Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 or 20 min</u> <u>1st seen Jan 3 -</u> <u>1959</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 3, 1959</u> to <u>Apr. 1, 1959</u> , that I last saw the deceased alive on <u>Mar. 28, 1959</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Coulbourn</u> M.D.		ADDRESS (Street, city or town, state) <u>MARION STATION - MD -</u> DATE SIGNED <u>4-4-59</u>	
PHYSICIAN'S NAME (Type) <u>George C. Coulbourn MD - Marion Sta. MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Byrd Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marion Sta., Som. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion Sta., MD.</u>		24a. REC'D BY REGISTRAR <u>APR 8 '59</u>	
ADDRESS <u>Marion Sta., MD. 235</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

Marion Station

Marion Station

Female Negro

George Forward
Dorchester Mary Emily Abbott

24-07-1912

Marion Station

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7, Film G241, 4/10/59
4768
CERTIFICATE OF DEATH

04750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRMOUNT		c. LENGTH OF STAY IN lb 35 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER FAIRMOUNT	
		d. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) First DAN Middle COLEMAN Last COLEMAN		4. DATE OF DEATH Month 4 Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE C OLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm Labor	
11. BIRTHPLACE (State or foreign country) WEST Virginia		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME ??		14. MOTHER'S MAIDEN NAME ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ANNIE GILES. POCOMOKE CITY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 15th 1957 to March 4, 1959 , that I last saw the deceased alive on March 3rd 1959 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edson G. Mautman		ADDRESS (Street, city or town, state) DATE SIGNED Princess Anne, MD	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/7/59	
22c. NAME OF CEMETERY OR CREMATORY CRIST M.E.		22d. LOCATION (City, town, or county) (State) PUNCH LANDEN MD	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR		ADDRESS PRINCESS ANNE, MD	
24a. REC'D BY REGISTRAR APR 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thane	

U.S. DEPARTMENT OF JUSTICE—FEDERAL BUREAU OF INVESTIGATION



FOR STATE
HEALTH DEPT.

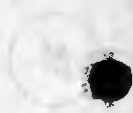
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04751
Reg. Dist. No.

4769

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MtVernon		c. LENGTH OF STAY IN 1b Life		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne R.F.D (MtVernon), Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lewis Donald Collins			4. DATE OF DEATH Month April Day 8 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1927		9. AGE (in years last birthday) 31 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) MtVernon Maryland	
13. FATHER'S NAME Arthur G. Collins			14. MOTHER'S MAIDEN NAME Ina B. Donald		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes War 11		16. SOCIAL SECURITY NO. 213-22-7258		17. INFORMANT Ina B. Collins Princess Anne R.F.D 2,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Twenty two rifle bullet into heart 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 0					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted rifle shot into heart			
20c. TIME OF INJURY Month, Day, Year 6:15 p. m. 4-8 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Near home	
20f. (City or town) MtVernon		20g. (County) Somerset		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>R. H. Johnson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 10, 1959	
EXAMINER'S NAME (Type) R. H. Johnson, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/11/59		22c. NAME OF CEMETERY OR CREMATORY Ashbury	
22d. LOCATION (City, town, or county) MtVernon Md.		22e. REC'D BY REGISTRAR APR 13 '59		22f. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Henman Princess Anne Md.</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

1968

1. Name of Deceased: JOHN J. BROWN
2. Date of Death: 10-15-68
3. Place of Death: 1234 Main St., New York, N.Y.
4. Age: 45 Sex: M
5. Race: W Religion: C
6. Cause of Death: Myocardial Infarction
7. Manner of Death: Natural
8. Signature of Examiner: [Signature]
9. Date of Certificate: 10-16-68

10. Medical History:	
11. Post-mortem Examination:	
12. Other Remarks:	

13. Signature of Physician	14. Signature of Medical Examiner
15. Signature of Coroner	16. Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7, Film G241, 4/16/59
4770
CERTIFICATE OF DEATH

04752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	
c. LENGTH OF STAY IN 1b 62 YRS.		d. STREET ADDRESS 1 MAIN STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WALDEN C DIZE		4. DATE OF DEATH Month Day Year APRIL 9 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-9-1896
9. AGE (In years, lay, and day) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRY CLEANER		10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME L. COOPER DIZE		14. MOTHER'S MAIDEN NAME PHOEBE WARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO.	
17. INFORMANT CLINTON DIZE Address CRISFIELD, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic Arteriosclerosis & Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Vascular Accident - 2 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/25 , 19 52 to 4/9 , 19 59 , that I last saw the deceased alive on 4/8 , 19 59 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. N. Barr		DATE SIGNED 4/9/59	
PHYSICIAN'S NAME (Type) A. N. BARR, M.D.		CRISFIELD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-11-59	22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md. ADDRESS		24a. REC'D BY REGISTRAR DATE APR 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Smith	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Office of registration	
13. Name of funeral home		14. Name of undertaker		15. Name of cemetery		16. Name of church	
17. Name of family		18. Name of next of kin		19. Name of executor		20. Name of administrator	
21. Name of guardian		22. Name of trustee		23. Name of agent		24. Name of attorney	
25. Name of executor		26. Name of administrator		27. Name of guardian		28. Name of trustee	
29. Name of agent		30. Name of attorney		31. Name of executor		32. Name of administrator	
33. Name of guardian		34. Name of trustee		35. Name of agent		36. Name of attorney	
37. Name of executor		38. Name of administrator		39. Name of guardian		40. Name of trustee	
41. Name of agent		42. Name of attorney		43. Name of executor		44. Name of administrator	
45. Name of guardian		46. Name of trustee		47. Name of agent		48. Name of attorney	
49. Name of executor		50. Name of administrator		51. Name of guardian		52. Name of trustee	
53. Name of agent		54. Name of attorney		55. Name of executor		56. Name of administrator	
57. Name of guardian		58. Name of trustee		59. Name of agent		60. Name of attorney	
61. Name of executor		62. Name of administrator		63. Name of guardian		64. Name of trustee	
65. Name of agent		66. Name of attorney		67. Name of executor		68. Name of administrator	
69. Name of guardian		70. Name of trustee		71. Name of agent		72. Name of attorney	
73. Name of executor		74. Name of administrator		75. Name of guardian		76. Name of trustee	
77. Name of agent		78. Name of attorney		79. Name of executor		80. Name of administrator	
81. Name of guardian		82. Name of trustee		83. Name of agent		84. Name of attorney	
85. Name of executor		86. Name of administrator		87. Name of guardian		88. Name of trustee	
89. Name of agent		90. Name of attorney		91. Name of executor		92. Name of administrator	
93. Name of guardian		94. Name of trustee		95. Name of agent		96. Name of attorney	
97. Name of executor		98. Name of administrator		99. Name of guardian		100. Name of trustee	

4763

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 127 Maryland Ave.		e. STREET ADDRESS 127 Maryland Ave.	
3. NAME OF DECEASED (Type or print) First CHARLES Middle WILLIAM Last GOLDSBOROUGH		4. DATE OF DEATH Month April Day 21 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1913
9. AGE (In years last birthday) yrs. 45		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert H. Goldsborough		14. MOTHER'S MAIDEN NAME Ella Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-3761	
17. INFORMANT Mrs. Frances Goldsborough, Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 hours
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 21, 1959 , to April 21, 1959 , that I last saw the deceased alive on April 21, 1959 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 334 Main St - Crisfield, Md. 4/22/59	
PHYSICIAN'S NAME (Type) Sarah M. Peyton, Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-24-59	22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		24a. REC'D BY REGISTRAR DATE APR 24 59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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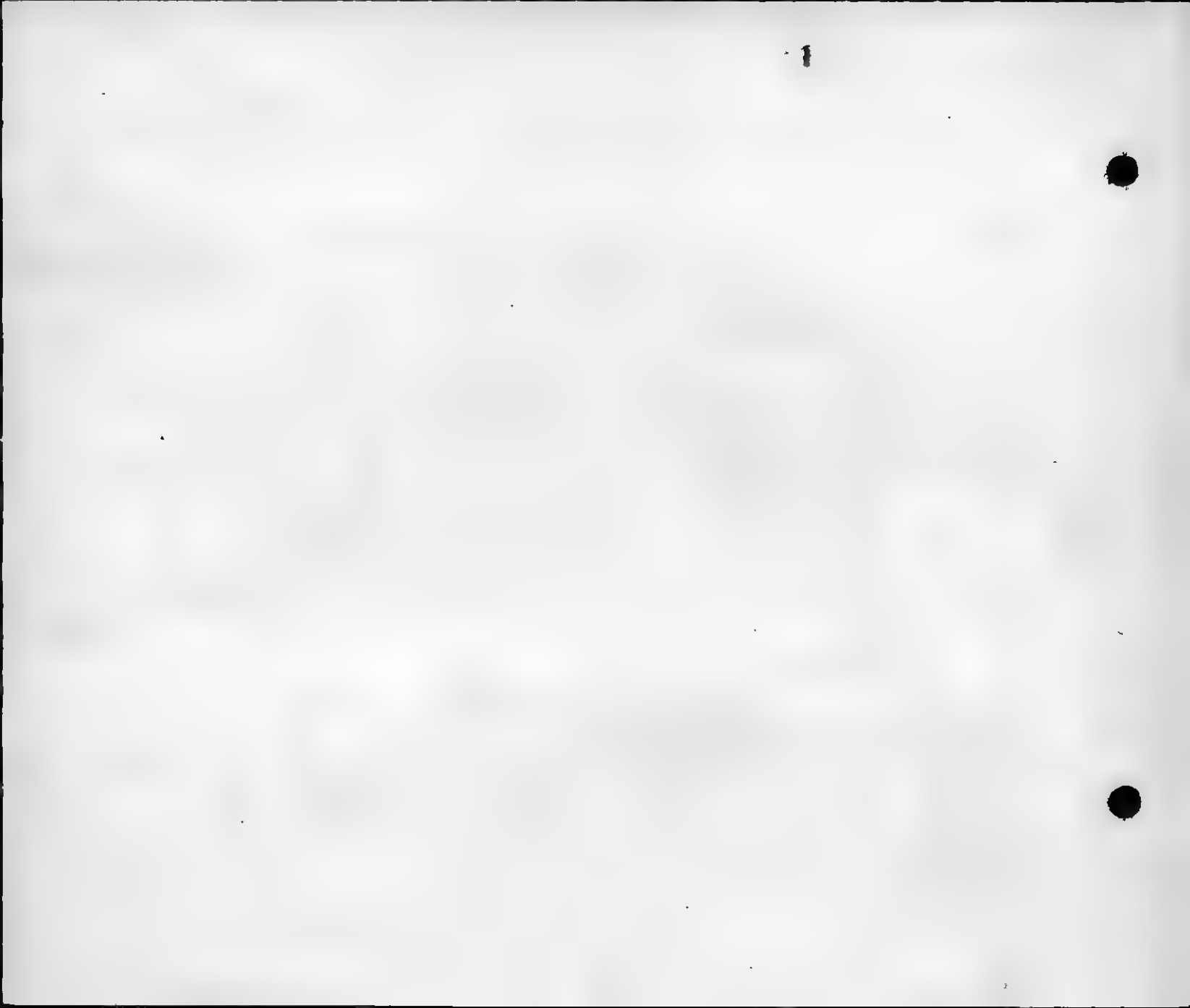
04754

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANCY M. GOLDSBOROUGH</u>		4. DATE OF DEATH Month Day Year <u>APRIL 10 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 27 - 1860</u>
9. AGE (In years last birthday) <u>98</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID M. NELSON</u>		14. MOTHER'S MAIDEN NAME <u>JULIA MCCREADY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Mayme Powell - Salisbury, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic Myocarditis</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>25 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Degeneration. Inanition</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 26</u> , 19 <u>53</u> , to <u>April 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>59</u> , and that death occurred at <u>11:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. N. Barr, M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>Crisfield, Maryland</u> DATE SIGNED <u>4/13/59</u>	
PHYSICIAN'S NAME (Type) <u>A. N. BARR, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>4-13-59</u>	<u>NELSON FAMILY CEMETERY</u>	<u>CRISFIELD MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Webster Crisfield, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Hanks</u>	

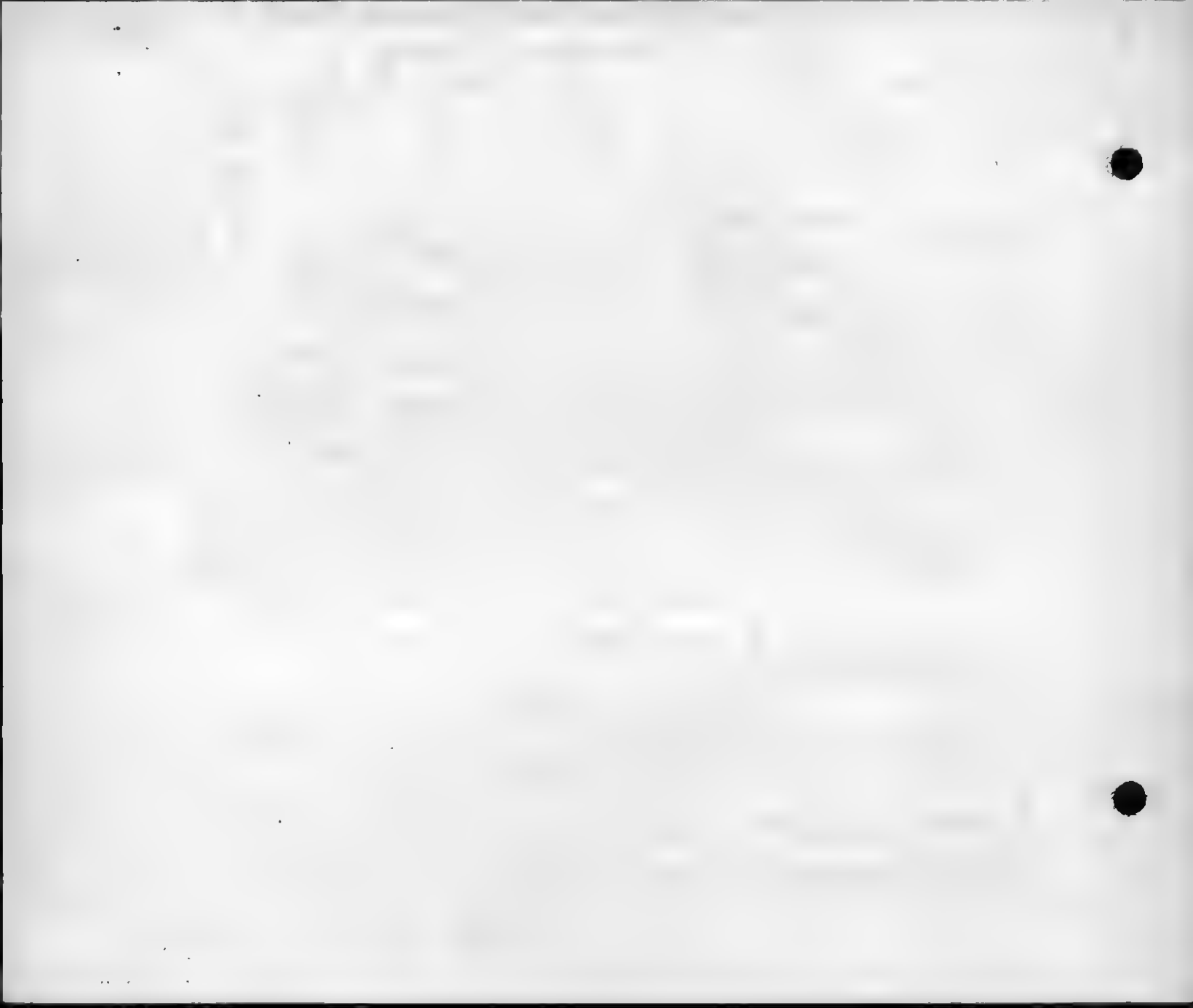
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and sample filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

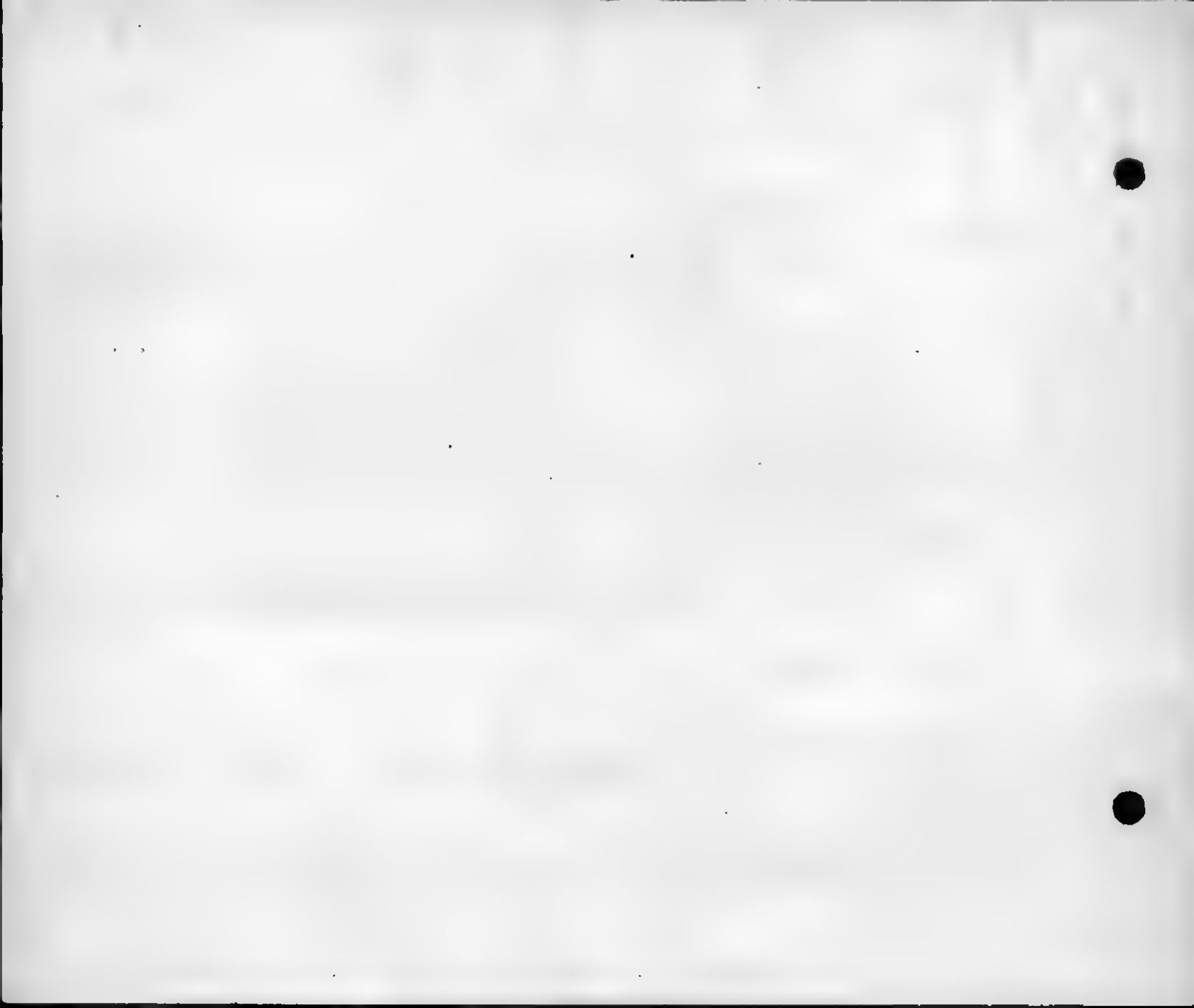
4772

CERTIFICATE OF DEATH

04755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Ann</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Princess Ann</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Linden Avenue</u>		d. STREET ADDRESS <u>Linden Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cliver</u> Middle <u>E.</u> Last <u>Handy</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willman Handy</u>		14. MOTHER'S MAIDEN NAME <u>Notknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>S.A.W.</u> <u>W.W.1.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Nettie V. Handy Princess Ann. Box 312</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Ap 13th</u> , 19 <u>59</u> , to <u>Ap 14th</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Ap. 13</u> , 19 <u>59</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Elton G. Markhsman</u> M.D. <u>Princess Anne, Md</u> PHYSICIAN'S NAME (Type) <u>Elton G. Markhsman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>South Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William C. Stewart</u>		ADDRESS <u>Salisbury, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



4775

Reg. Dist. No.

VS. A15ME
SM 2/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04758

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

4774

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dames Quarter</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Dames Quarter</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First <u>Marvin</u> Middle <u>Lee</u> Last <u>Lawson</u>			4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1959</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>January 9, 1959</u>		9. AGE (In years last birthday) <u>0</u> yrs		10. IF UNDER 1 YEAR <u>3</u> Months <u>12</u> Days	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland (Hosp.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Mervin Corbin</u>			14. MOTHER'S MAIDEN NAME <u>Emma White</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address <u>Emma Lawson - Dames Quarter, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/22/59</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dames Quarter Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>Dames Quarter, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Hume</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Princess Anne, Md.</u>					

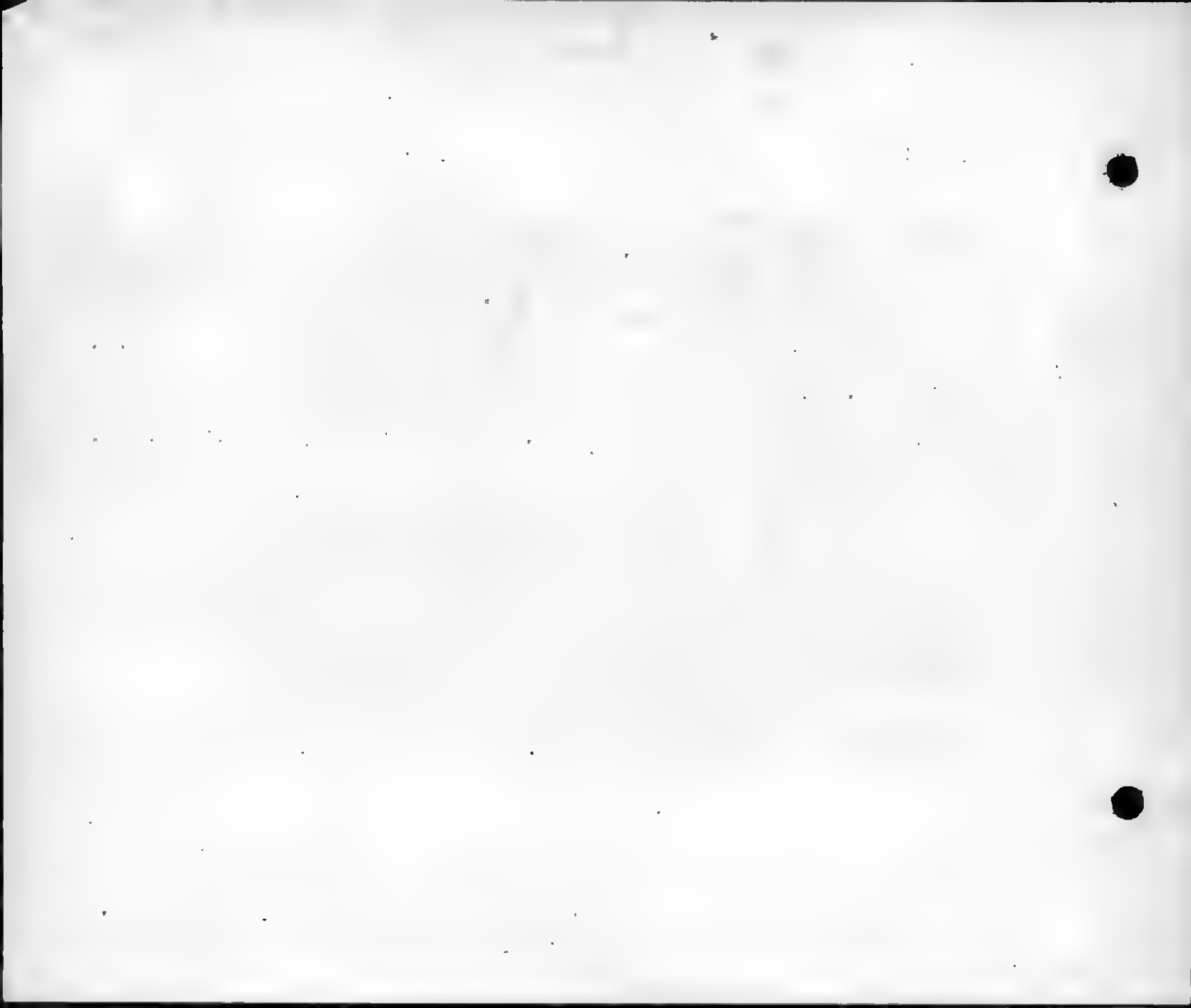
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (If deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle E. Maddrix Last 4. DATE OF DEATH Month April Day 26 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1876
9. AGE (In years last birthday) yrs 82		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor & Builder		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George E. Maddrix		14. MOTHER'S MAIDEN NAME Angella Sterling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Olivia Maddrix, Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <input type="checkbox"/> m. <input type="checkbox"/> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 24, 1957 , to April 26, 1957 , that I last saw the deceased alive on April 26, 1957 , and that death occurred at M , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED South M. Peyton MD 33 W. Main - Crisfield 4/20/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James L. Homan			
22a. BURIAL, CREMATION, or other disposition (Specify) buried		22b. DATE THEREOF 4/28/59	
22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Homan		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Homan			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04760

Reg. Dist. No.

4775

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	
c. LENGTH OF STAY IN 1b 80 YRS.		d. STREET ADDRESS MARINERS ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS WARREN MASON	First Middle Last	4. DATE OF DEATH APRIL 1 1959	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 - 15 - 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MASON		14. MOTHER'S MAIDEN NAME LAURETTA ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 218-20-5485	
17. INFORMANT THOMAS MASON, GIRDLETREE, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4:30 P.M. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 min. 3 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4/11/59 Influenza - 3 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/11/59 10:40 A.M. to 4/11/59 19:57 that I last saw the deceased alive on 4/11 , 19 59 , and that death occurred at 4:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND DATE SIGNED 4/12/59			
ACTUAL SIGNATURE A. N. BARR, M.D. M.D.		CRISFIELD, MARYLAND	
PHYSICIAN'S NAME (Type) A. N. BARR, M.D.		CRISFIELD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr 4, 1959	22c. NAME OF CEMETERY OR CREMATORY Mariners Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		24a. REC'D BY REGISTRAR APR 7 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4776

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

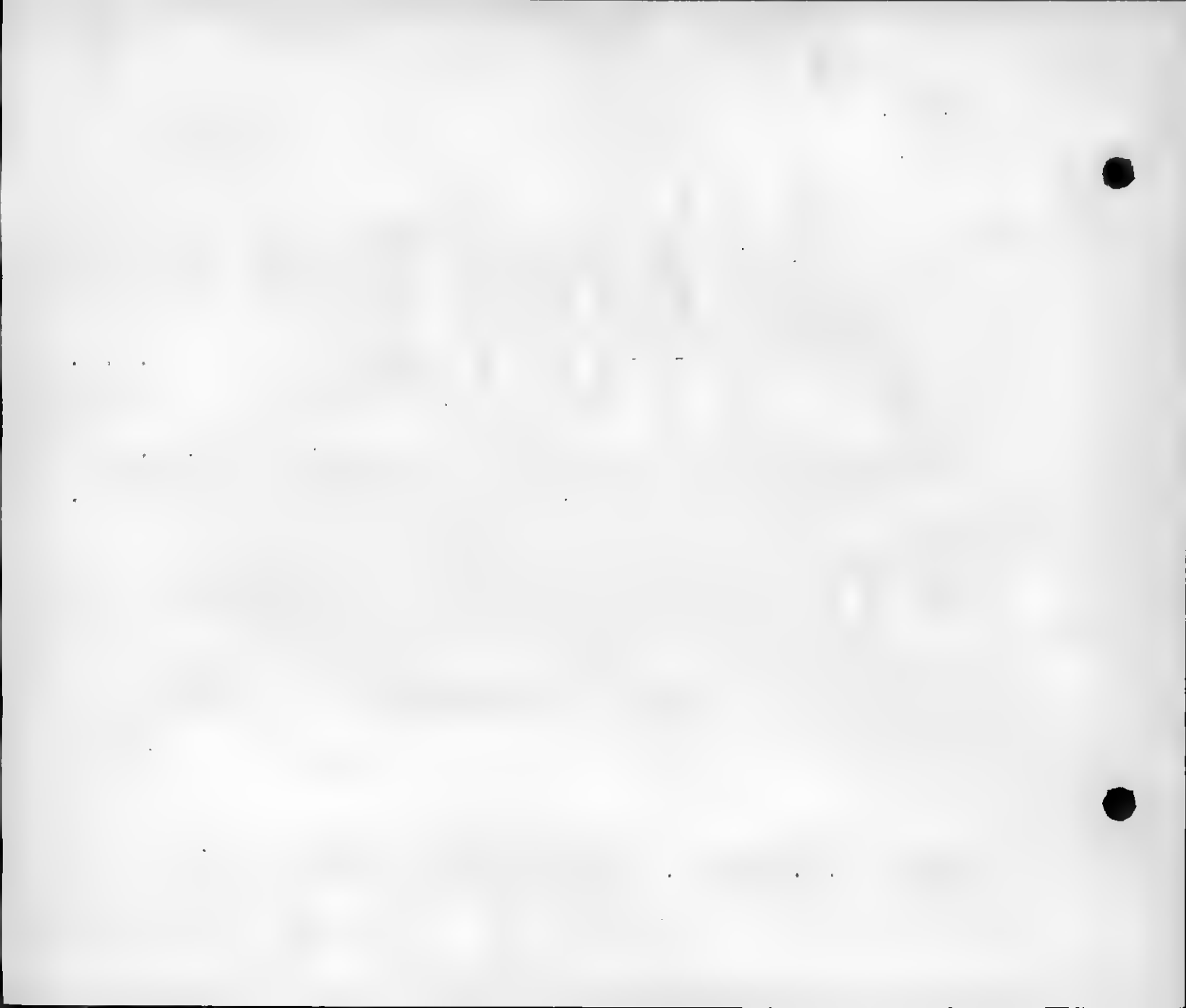
04761

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lower Fairmount Maryland</u>		c. LENGTH OF STAY in 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Lower Fairmount, Maryland</u>	
3. NAME OF DECEASED (Type or print) First <u>Mitzi</u> Middle <u>Ann</u> Last <u>Parkinson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 25, 1958</u>
9. AGE (In years last birthday) <u>0</u> yrs		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jack Phillip Parkinson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Ellen Ford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Jack Parkinson, Upper Fairmount, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>499X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>18 Hrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		DATE SIGNED <u>April 6, 1958</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-6-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Wenona, Maryland - Somerset Co.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster</u>		24a. REC'D BY REGISTRAR <u>Seal</u>	
24b. REGISTRAR'S SIGNATURE <u>Seal</u>		DATE <u>4/6/59</u> APR 9 59	

21-22-23-24



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4766

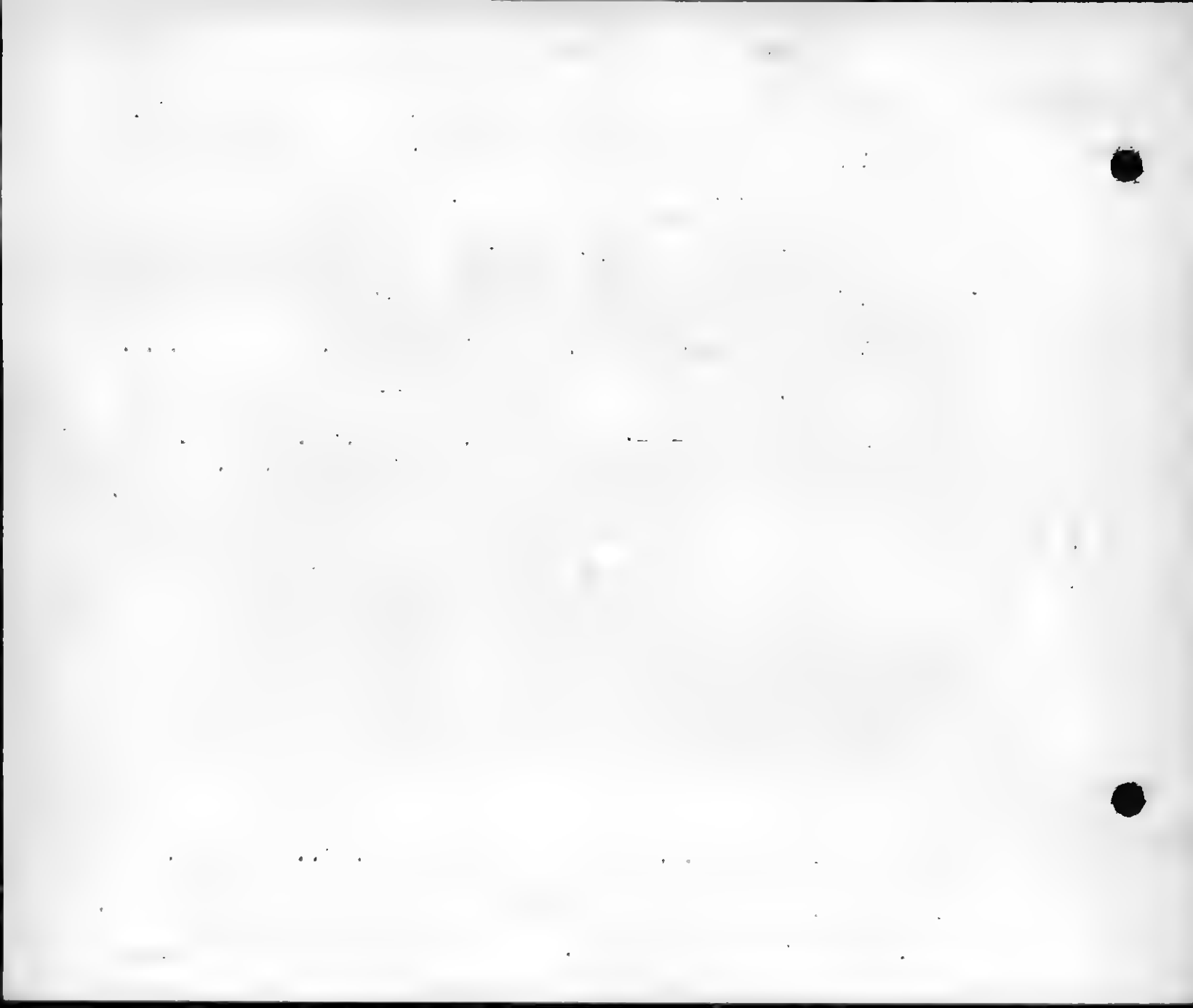
CERTIFICATE OF DEATH

04762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD				c. LENGTH OF STAY IN 1b 20 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEST MAIN STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle ANTHONY Last QUINN				4. DATE OF DEATH Month APRIL Day 9 Year 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 10, 1897		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY CUTLERY MFG.		11. BIRTHPLACE (State or foreign country) KENT COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES R. QUINN				14. MOTHER'S MAIDEN NAME JANE E. MULLIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW I 222-07-7068		INFORMANT Address DANIEL J. QUINN--R.F.D. BOX 8--KENNEDYVILLE,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 420.1 DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary thrombosis acute (c) Senil arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 hr - yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 47 to April 9, 19 59 that I last saw the deceased alive on April 9, 19 59 , and that death occurred at 1 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. G. Rawley		M. D.		ADDRESS (Street, city or town, state) CRISFIELD, MD.		DATE SIGNED 4/9/59	
PHYSICIAN'S NAME (Type) C. G. RAWLEY, M.D.		MAIN ST.—CRISFIELD, MD.					
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY LAMBSON CEMETERY		22d. LOCATION (City, town, or county) (State) GALENA, KENT COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS—CRISFIELD, MD.				24a. REC'D BY REGISTRAR DATE APR 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kane	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

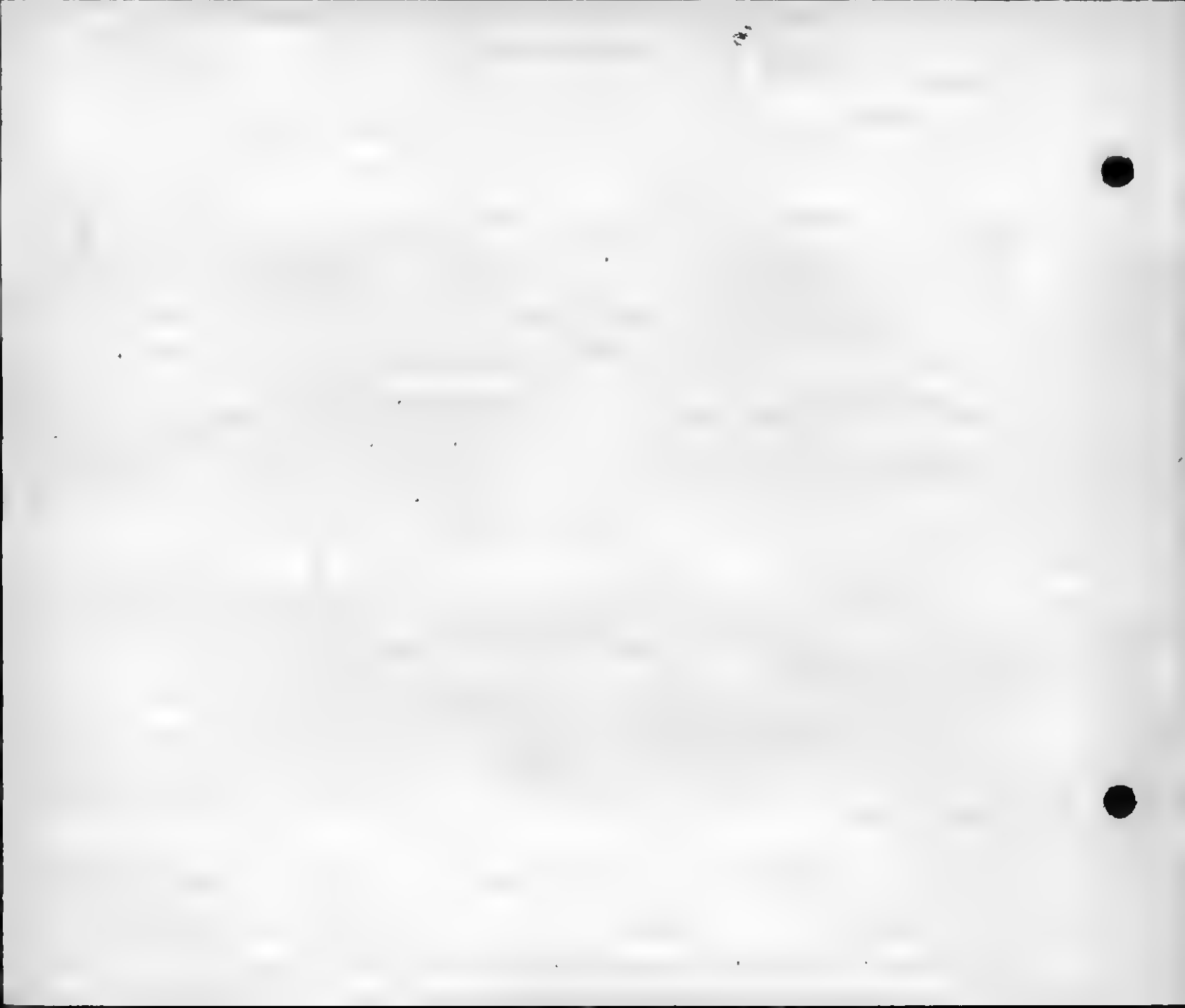
Item 9 Film G241 4-23-59 et

4777

04763

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Venton				c. LENGTH OF STAY IN 1b Life Time			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle H. Last SMITH				4. DATE OF DEATH Month 4 Day 19 Year 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/1877		9. AGE (In years) 82 yrs.	IF UNDER 1 YEAR Months 8 Days 8 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME HANDY SMITH				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME JULIA A. DESHIELDS			
16. SOCIAL SECURITY NO.				17. INFORMANT CECILE E. SMITH, PRINCESS ANNE, MD RT # 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arthritis						INTERVAL BETWEEN ONSET AND DEATH 4 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Th		
20f. (City or town) Th			20g. (County) Th			20h. (State) Th	
21. I certify that I attended the deceased from Jan 24 , 19 59 , to April 19 , 19 59 , that I last saw the deceased alive on April 15 , 19 59 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Eldon G. Markman				ADDRESS (Street, city or town, state) Princess Anne, Md			
PHYSICIAN'S NAME (Type) ELDON G. MARKMAN				DATE SIGNED 1			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/59		22c. NAME OF CEMETERY OR CREMATORY Grace		22d. LOCATION (City, town, or county) (State) VENTON MD	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR. PRINCES ANNE, MD				24a. REC'D BY REGISTRAR DATE APR 21 '59		24b. REGISTRAR'S SIGNATURE William E. Thomas	

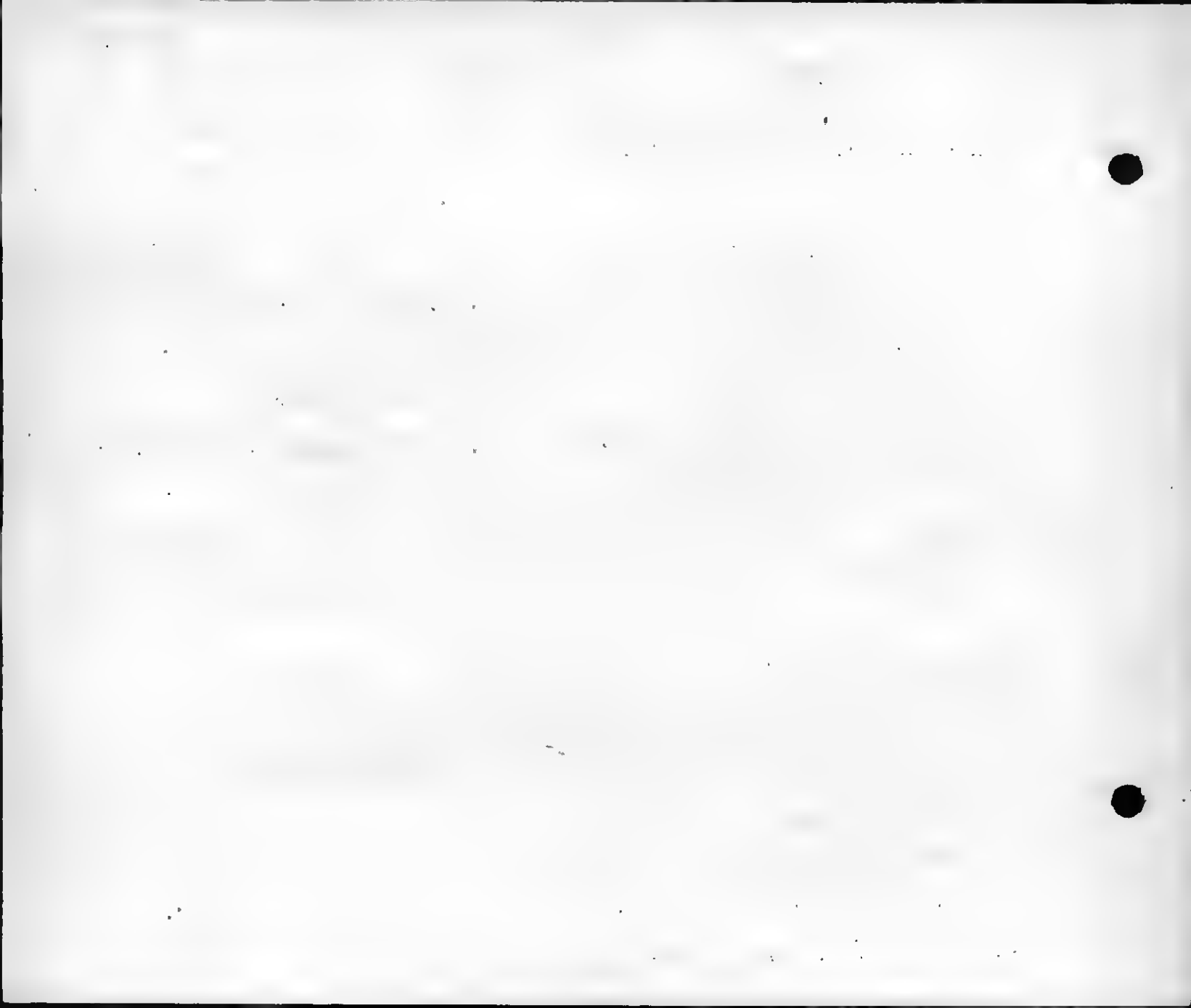


CERTIFICATE OF DEATH

04764
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived If institution residence before admission) o. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Crisfield		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS R.F.D.#1	
3. NAME OF DECEASED (Type or print) First Delware Middle Tyler Last Tyler		4. DATE OF DEATH Month April Day 30 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Tyler		14. MOTHER'S MAIDEN NAME Harriet Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 213 -09-4923	
17. INFORMANT Mrs. Sally Tyler, Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x DUE TO Nephritis - terminal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO Arteriosclerosis (c) Heart failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs 3 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr. 20 , 19 59 , to Apr. 30 , 19 59 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton		ADDRESS (Street, city or town, state) 334 W. Main Crisfield	
PHYSICIAN'S NAME (Type) Sarah M. Peyton		DATE SIGNED 5/4/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 5/3/59	22c. NAME OF CEMETERY OR CREMATORY Asbury	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Samuel L. Hannon		24a. REC'D BY REGISTRAR DATE MAY 6 '59	
ADDRESS Crisfield, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hannon	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04765
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

4779

1. PLACE OF DEATH a. COUNTY SOMerset MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne R. F. D.		c. LENGTH OF STAY IN 1b 5 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, R. F. D.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Perry Vaughan			4. DATE OF DEATH April 14 19 59		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1885		9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Norfolk Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Jessie Vaughan		
14. MOTHER'S MAIDEN NAME Mary ?			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 231-09-0691			17. INFORMANT Elizabeth Cooper, Camden N. J.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Asthma 241 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R. H. Johnson		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. H. Johnson M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 16, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	
22d. LOCATION (City, town, or county) Princess Anne, Md.		22e. (State)		22f. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Johnson Jr.		ADDRESS Princess Anne		24a. REC'D BY REGISTRAR DATE APR 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
RECORDS

1933

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Death: Jan 15, 1933

5. Time of Death: 10:00 AM

6. Place of Death: Home

7. Cause of Death: Heart Disease

8. Manner of Death: Natural

9. Signature of Medical Examiner: [Signature]

10. Signature of Coroner: [Signature]

11. Signature of Physician: [Signature]

12. Signature of Family Member: [Signature]

13. Signature of Witness: [Signature]

14. Signature of Another Witness: [Signature]

15. Signature of Another Witness: [Signature]

16. Signature of Another Witness: [Signature]

17. Signature of Another Witness: [Signature]

18. Signature of Another Witness: [Signature]

19. Signature of Another Witness: [Signature]

20. Signature of Another Witness: [Signature]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4780 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 5, Film G212, 5-8-59 md

04766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Edward McCready Hospital		d. STREET ADDRESS 331 Broadway	
3. NAME OF DECEASED (Type or print) Leon Whittington		4. DATE OF DEATH April 30 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaford Worker		10b. KIND OF BUSINESS OR INDUSTRY Marion Station	
13. FATHER'S NAME Sherman Whittington		14. MOTHER'S MAIDEN NAME Gertrude Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-01-2373	
17. INFORMANT Harriett Whittington		Address 331 Broadway	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO (b) Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 4-30-59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crisfield (County) Somerset (State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm H Coulbourn M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Wm H Coulbourn M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM John Wesley M.E.		22d. LOCATION (City, town, or county) Marion Sta, Som. Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Hard		24a. REC'D BY REGISTRAR Arthur L. Hanes	
ADDRESS Marion Sta., Md.		24b. REGISTRAR'S SIGNATURE	
		DATE MAY 5 '59	

William H. Coulbourn, M.D.
DEPUTY MEDICAL EXAMINER
FOR SOMERSET COUNTY, MD.

DATE SIGNED **April 30-1959**

Johnson R.

115

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Followed the Creek - Ho-yita - all Broad way

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W. H. H. W.

April 30 1907

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4th of 1907

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Thermon Whittington

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218-1-233 Amherst V. Pittsford - (Crestfield, Va.)

18-19-20

12-13

4

PC 102-4

William Lloyd Garrison

11/11/11

14/11/2000-17/11/00

1902-1903

Charles H. Wesley, The
Barnes & Co., New York